CHAPTER VI

UTILIZATION REVIEW AND CONTROL

CHAPTER VI
TABLE OF CONTENTS

Introduction 1

Compliance Reviews 1

Fraudulent Claims 2

- Provider Fraud 2
- Recipient Fraud 3

Referrals to the Client Medical Management Program 3

Utilization Review of the Provider for Elderly and Disabled Waiver Services 4

- Required Documentation for Recipient Records for Personal/Respite Care 5
- Required Documentation for Recipient Records for ADHC 6
- Required Documentation for Recipient Records for Personal Emergency Response Systems (PERS) 7

Medical Records and Record Retention 8

Provider Participation Standards 8

Financial Review and Verification 8

- Personal/Respite Care Services 8
- Adult Day Health Care Services 9

Exit Conference 9

Reimbursement Requirements 9

- Personal Care 9
- Respite Care 10
- Adult Day Health Care 11
- Personal Emergency Response System (PERS) 12

Provider Appeal Process: Utilization Review Denial of Reimbursement 13

Recipient Appeals 14

Provider Sanctions (Adverse Actions) 14

CHAPTER VI
UTILIZATION REVIEW AND CONTROL

INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by recipients. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic utilization reviews on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by DMAS.

COMPLIANCE REVIEWS

The Department of Medical Assistance Services routinely conducts compliance reviews to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455. Providers and recipients are identified for review by systems generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group. An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases using available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Statistical sampling and extrapolation may be used in a review. The Department may use a random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the amount of invalid payments in the audit sample are compared to the total invalid payments for the same time period, and the total amount of the overpayment is estimated from this sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, Medicaid may restrict or terminate the provider's participation in the program.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Since payment of claims is made from both State and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or State court. The Program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable State and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit

Office of the Attorney General
900 E. Main Street, 5th Floor
Richmond, Virginia 23219

Recipient Fraud

Allegations about fraud or abuse by recipients are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See the "Exhibits" section at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate recipients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. An answering machine receives after-hours

referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-6548
CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the recipient and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

UTILIZATION REVIEW OF THE PROVIDER FOR ELDERLY AND DISABLED WAIVER SERVICES

The purpose of utilization review (UR) is to determine whether services delivered were appropriate, whether services continue to be needed, and the amount and kind of services required. Utilization review is mandated to ensure that the health, safety, and welfare of the recipients are protected and to assess the quality, appropriateness, level, and cost-effectiveness of care.

DMAS analysts conduct utilization review of all documentation submitted by the provider which shows the recipient's level of care. Visits are conducted on-site and will be unannounced.

The UR visit is accomplished through a review of the recipient's record, evaluation of the recipient's medical and functional status, review of the provider qualifications, and consultation with the recipient and family members.

When the utilization review team arrives at the provider's place of business/offices, the team will request one record per team member in order to begin the utilization review process. The utilization review team will also request the provider to provide the rest of the records on the review list within two (2) hours of their arrival time for open records and by close of business on the arrival day for closed records.

During an on-site review, the utilization review analyst will review the recipient's record in the provider's place of business/offices, paying specific attention to plans of care, RN Supervisory notes, daily records, progress notes, screening packages, and any other

documentation that is necessary to determine if appropriate payment was made for services rendered. The UR analyst will also meet or talk with at least one recipient or primary caregiver to determine recipient satisfaction with the E&D Waiver services and the provider. The provider may be asked to assist in setting up this visit. In all cases, the primary caregiver is encouraged to participate in the DMAS review of the recipient's care.

During the review process, the analyst will be available to offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures. A letter will be sent to the provider within 30 days after the review is complete to either document the results of the review or provide an update or status of the review.

Required Documentation for Recipient Records for Personal/Respite Care

The provider shall maintain a record for each recipient. These records must be separated from those of other services, such as companion services or home health. If a recipient receives personal care and respite care services, one record may be maintained, but separate sections should be reserved for the documentation of the two services. The following information may be reviewed during the utilization review process:

- The Pre-Admission Screening Assessment (UAI); the Nursing Home Pre-Admission Screening Authorization signed by all members of the Screening Team (DMAS-96); the Screening Team Plan of Care (DMAS-97 or DMAS-300 for Respite Care services); DMAS-101 (for all recipients with a diagnosis of MI or MR); all provider Plans of Care (DMAS-97A); Supervision Request Form (DMAS-100); and all DMAS-122s;

- The initial assessment (DMAS-99) by the RN supervisory nurse completed prior to service initiation. This must be filed in the recipient's record within five working days from the date of the visit. (See Chapter IV for the content of the initial assessment.) Only the DMAS-99 can be used for nursing assessments. The Comprehensive Adult Nursing Assessment form, or OASIS form, is not acceptable.

- The staff's personnel files must verify that the minimum qualifications outlined in Chapter II are met.

- All RN supervisory notes (DMAS-99) completed during the required 30-day visits must be on file within two weeks of the date of the visit. Nursing notes must be in the recipient's record within five days of the last supervisory visit made to the recipient. Any supervisory visit not documented and present in the recipient's record will be considered as not having been made. Nursing notes must reflect all significant contacts with the recipient. It must be documented that the registered nurse has made a supervisory visit (with the aide present at least every other visit) in the recipient's home at least every 30 days following the initial visit. The RN supervisor's documentation must include the observations of the recipient made during the visits as well as any instruction, supervision, or counseling provided to the aide working with the recipient. The RN supervisor's notes must also clearly document that he or she has discussed

with the recipient or family member the appropriateness and adequacy of service. Client satisfaction with the services should be documented as well as all requirements for RN supervisor and documentation found in Chapter II of this manual.

- All provider contacts with the recipient, family members, health professionals, WVMI, DMAS, etc. All notes must be filed in the recipient's records within two weeks. Whiteout must not be used to make corrections to the file. Any corrections made to the recipient's record must be initialed and dated;

- Personal/Respite Care Aide record (DMAS-90) of services rendered and the recipient's responses. The Aide Record (DMAS-90) must be thoroughly completed. The Aide Record must document the care given and the times of arrival to and departure from the recipient's home each day the aide renders service. The records must be signed weekly by the aide, and the recipient. In instances where the recipient is unable to sign and there is no family member or other legal representative to do so, the reason for the absence of this signature must be thoroughly documented on the DMAS-90. The aides' weekly comments should note significant physical, social, and emotional aspects of the recipient's life that week. The aide record sheets must be in the recipient's record within two (2) weeks; and

- A copy of the recipient's living will and durable power of attorney (if applicable).

Required Documentation for Recipient Records for ADHC

The following information may be reviewed during the utilization review process:

- The ADHC daily records (DMAS-302) must be thoroughly completed. The records must document the care given and the times of arrival and departure from the center each day. The records must be signed weekly by an ADHC professional. The staff's weekly comments should note significant physical, social, and emotional aspects of the recipient's life during that period. The weekly comment section must be completed unless that information is contained elsewhere in the recipient's record. The recipient's family must be sent a copy of the weekly records;

- The professional staff's 30-day progress notes should describe the recipient's medical/functional status, note any change in social support status, indicate any other services received by the recipient (to include personal or respite care services also under the E&D Waiver), and reference a review of any rehabilitative therapy 30-day progress notes received;

- Professional notes must reflect all significant contacts with the recipient, family members, and any other professionals involved in the recipient's health care delivery;

- The original UAI, DMAS-96, DMAS-97, DMAS-101 (for all recipients with a diagnosis of MI/MR), and DMAS-301 must be in the recipient's record. The current and prior DMAS-122s and DMAS-302s must also be in the recipient's record;

- The professional staff's personnel files must verify that all staff meet the minimum qualifications outlined in Chapter II;

- The initial interdisciplinary Plan of Care (DMAS-301), all subsequent three-month interdisciplinary evaluations and any changes to the plan of care must be in the recipient's record. The three-month interdisciplinary evaluation should indicate the reason for any change in the recipient's plan of care and state whether ADHC continues to be an appropriate long-term care service;

- All provider contacts with the recipient, family members, health professionals, DMAS, WVMI, etc. All notes must be filed in the recipient's records within two weeks. Whiteout must not be used to make corrections to the file. Any corrections made to the recipient's record must be initialed and dated; and

- A copy of the recipient's living will and durable power of attorney (if applicable).

During the UR visit, DMAS may interview recipients in the provider's place of business/facility to evaluate the recipient's condition, satisfaction with the service, and the appropriateness of the current plan of care. The ADHC center may be requested by the analyst to have the recipient's primary caregiver available for this interview. In all cases, the primary caregiver is encouraged to participate in the DMAS review of the recipient's care.

The Utilization Review staff will visit or talk to at lease one recipient to review the appropriateness, quality, and level of care received. If the plan of care is found to be inappropriate, the analysts may change hours, level of care, or terminate services. The analysts will evaluate the client's condition, satisfaction with the service, and appropriateness of the current plan of care.

<u>Required Documentation for Recipient Records for Personal Emergency Response Systems (PERS)</u>

The PERS provider must maintain a data record for each PERS recipient at no additional cost to DMAS. The record shall contain the following and may be reviewed during the utilization review process:

- Delivery and installation date of the PERS;
- Enrollee/caregiver signature verifying receipt of the PERS device;
- Verification by a test that the PERS device is operational, monthly or more frequently as needed;
- Updated and current recipient responder and contact information, as provided by the recipient or the recipient's caregiver; and

- A case record documenting recipient system utilization and recipient or responder contacts/communications.

MEDICAL RECORDS AND RECORD RETENTION

The provider must recognize the confidentiality of recipient medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern medical record use and removal and the conditions for the release of information. The recipient's written consent is required for the release of information not authorized by law. Current recipient medical records and those of discharged recipients must be completed promptly. All clinical information pertaining to a recipient must be centralized in the recipient's clinical/medical record.

Records of E&D Waiver services must be retained for not less than five years after the date of discharge. The provider must maintain medical records on all recipients in accordance with accepted professional standards and practice. The records must be completely and accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information. All E&D Waiver medical record entries must be fully signed and dated (month, day, and year) including the title (professional designation) of the author.

PROVIDER PARTICIPATION STANDARDS

During the on-site review, the utilization review analysts will monitor the provider's compliance with overall provider participation requirements. Particular attention is given to staffing qualifications as described in Chapter II of this manual. The analysts will need to see all RN licenses and certificates of all aides who have provided personal care services, as well as work references (or proof in the personnel file of a good faith effort to obtain such references) and obtain a criminal background check within 30 days of the date of hire. During this review, the analysts will discuss with the provider's administration the provider's overall status as a Medicaid provider, any areas of concern, technical assistance needs, the plans for addressing those needs, and any recommendations the analysts may have.

FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to ensure that the provider bills only for those services which have been provided in accordance with DMAS policy and which are covered under the E&D Waiver. The Utilization Review Analyst will also ensure that the appropriate patient pay amounts, if any, have been applied. Any paid provider claim which cannot be verified at the time of utilization review cannot be considered a valid claim for services provided, and retraction of payment may be necessary.

Personal/Respite Care Services

The aide's records (DMAS-90) must support the number of hours billed to DMAS. Only DMAS-90s will be used by DMAS to verify services delivered and billed to DMAS. No

other documentation (i.e., time sheets) will be used for verification of services. If services billed to and paid by DMAS are not documented on the DMAS-90, DMAS will require the provider to refund Medicaid. (See Chapter V for billing procedures.)

Adult Day Health Care Services

The adult day health care center's daily records (DMAS-302) must support the number of units billed to DMAS. Only DMAS-302s will be used by DMAS to verify services delivered and billed to DMAS. No other documentation (i.e., time sheets) will be used for verification of services. If services billed to and paid by DMAS are not documented on the DMAS-302, DMAS will require the provider to reimburse Medicaid. (See Chapter V for billing procedures.)

Billing for PERS must be supported by documentation regarding the installation of and training required to use the required device. Monthly billing for the ongoing monitoring services must be supported by documentation of at least monthly testing of the PERS device as well as documentation of each emergency signal which results in action being taken on behalf of the recipient.

EXIT CONFERENCE

Following the analyst's review of the records and home visits, the analyst will meet with the provider staff to discuss general findings from the reviews. The provider may include any staff the provider would like to attend.

The provider will be informed of the number of records reviewed, number of participants interviewed, general recommendations regarding level of care issues, general recommendations regarding changes in plans of care, and any pertinent information regarding documentation, service verification issues, quality of care, or provision of services. The provider is expected to use the findings of the utilization review to comply with regulations, policies, and procedures in the future. Records that have been reviewed shall not be altered to meet the compliance issues. The analyst will send a letter to the provider within 30 business days verifying that the review was conducted and describing findings from the review. This letter will also include a list of any retractions.

REIMBURSEMENT REQUIREMENTS

Elderly and Disabled Waiver services that fail to meet DMAS criteria are not reimbursable.

Personal Care

DMAS criteria for reimbursement of personal care services are found throughout the provider manual and include all of the following, but are not limited to:

- preadmission Screening Committee/Team authorization not obtained prior to initiation of services;
- DMAS authorization not obtained prior to initiation of services;

- current MAP-122 not found in recipient's record; no documentation showing a request for MAP-122 in recipient's record;
- patient pay indicated on DMAS-122, but not indicated on HCFA-1500;
- RN not qualified to provide services;
- no initial RN supervisory visit prior to initiation of services;
- RN supervisory visit late; explanation not documented;
- RN supervisory visit note is not comprehensive;
- personal care aide not qualified to provide services;
- aide records do not contain signatures of aide and caregiver/recipient; the reason for the absence of these signature(s) is not thoroughly documented on the DMAS-90;
- aide records do not contain the arrival and departure time for each day of service;
- hours of care provided exceeds authorized amount of hours; preauthorization not obtained from WVMI;
- inappropriate use of authorized hours;
- no documentation of services billed;
- current criminal history check not found in the employee's personnel file; and
- provider over-billed DMAS.

Respite Care

DMAS criteria for reimbursement of respite care services are found throughout the provider manual and include all of the following, but are not limited to:

- preadmission Screening Committee/Team authorization not obtained prior to initiation of services;
- DMAS authorization not obtained prior to initiation of services;
- current MAP-122 not found in recipient's record; no documentation showing a request for MAP-122 in recipient's record;

- patient pay indicated on DMAS-122, but not indicated on HCFA-1500;
- inappropriate use of respite care;
- RN not qualified to provide services;
- no initial RN supervisory visit prior to initiation of services;
- RN supervisory visit late; explanation not documented;
- RN supervisory visit note not comprehensive:
- respite care aide not qualified to provide services;
- aide records do not contain signatures of aide and caregiver/recipient; the reason for the absence of these signatures is not thoroughly documented on the DMAS-90;
- aide records do not contain the arrival and departure time for each day of service;
- LPN not qualified to provide services;
- LPN providing respite care when the recipient does not have a skilled need;
- hours of care provided exceeds authorized amount of hours; preauthorization not obtained from WVMI;
- inappropriate use of authorized hours;
- no documentation of services billed;
- current criminal history check not found in the employee's personnel file; and
- provider overbilled DMAS.

Adult Day Health Care

DMAS criteria for reimbursement of ADHC services are found throughout the provider manual and include all of the following, but are not limited to:

- preadmission Screening Committee/Team authorization not obtained prior to initiation of services;
- DMAS authorization not obtained prior to initiation of services;
- patient pay indicated on DMAS-122, but not indicated on HCFA-1500;

- the ADHC participant resides in a nursing facility, an intermediate facility for the mentally retarded, a hospital, or an adult home licensed by DSS;
- the ADHC center does not have a current DSS license;
- the ADHC center does not employ or subcontract with a Registered Nurse who is licensed to practice in Virginia;
- RN not qualified to provide services;
- the RN is not present at the ADHC a minimum of one day (eight hours) each month;
- program aide is not qualified to provide services;
- daily records do not contain the arrival/departure times for each day of service;
- 30 day progress note missing;
- daily records are not signed or co-signed on a weekly basis by a professional staff member;
- interdisciplinary staff meetings, to reassess each Medicaid participant and evaluate the adequacy of the plan of care, are not being held at least every three months;
- days of care provided exceeds authorized amount of days; preauthorization not obtained from WVMI;
- no documentation of services provided and billed;
- current criminal history check not found in the employee's personnel file; and
- the provider over-billed DMAS.

Personal Emergency Response System (PERS)

DMAS criteria for reimbursement of PERS are found throughout the provider manual and include all of the following, but are not limited to:

- DMAS authorization not obtained prior to initiation of services;
- The provider does not meet the qualifications of a PERS provider as specified in Chapter II of the Elderly and Disabled Waiver Manual;
- No documentation of services provided and billed to DMAS.
- Over billing of services to DMAS;

- Recipient does not meet criteria for PERS:
  - the recipient under the age of 14;
  - the recipient is not alone for significant parts of the day or who has a regular caregiver;
  - the recipient does not require extensive routine supervision;
  - someone else other than the recipient is in the home and is competent and continuously available to call for help in an emergency;
  - the recipient's caregiver has a business in the home and PERS was provided when the recipient was not evaluated as being dependent in orientation and behavior;
- The PERS provider fails to document and furnish the Personal Care, Respite, or Adult Day Health Care provider(s) of the recipient a report for each emergency signal that results in action being taken on behalf of the recipient. This excludes test signals or other signals made in error.

PROVIDER APPEAL PROCESS: UTILIZATION REVIEW DENIAL OF REIMBURSEMENT

Payment to providers of E&D Waiver services may be retracted or denied when the provider has failed to comply with the established federal and state regulations or policy guidelines.

If the E&D Waiver services provider chooses to appeal the request for retractions or denials, they may request reconsideration. The request for reconsideration and all supporting documentation, must be submitted within 30 days of written notification of the retraction and/or denial to:

Supervisor, Waiver Services Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DMAS will review the documentation submitted and provide the E&D Waiver services provider with a written response to the request for reconsideration. If the decision to retract or deny is upheld, the provider has the right to appeal the reconsideration decision by requesting an informal appeal within 30 days of the written notification of the reconsideration decision. The provider's request should include all information as to why the retraction or denial should not be made. The notice of appeal and supporting documentation shall be sent to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If the decision to retract or deny is upheld, the provider has the right to appeal the informal appeal decision by requesting a formal appeal within 30 days of the written notification of the informal appeal decision. The notice of appeal and supporting documentation shall be sent to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

RECIPIENT APPEALS

If a denied service has not been provided to the recipient, the denial may be appealed only by the recipient or his or her legal representative. Recipient appeals must be submitted within 30 days of the receipt of the written notification of the denial to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

PROVIDER SANCTIONS (ADVERSE ACTIONS)

The analyst will notify the provider of any retractions or denials of reimbursement. A retraction of reimbursement means that the provider will have to refund reimbursement that was paid inappropriately. A disallowance means that the provider will be prevented from billing for services, which were not in accordance with DMAS policy.

Pursuant to § 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate pursuant to § 32.1-313.1 of the Code of Virginia. Repayment and interest will not apply pending appeal. The DMAS Fiscal Division will coordinate the collection of any payments due to DMAS.